IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

July 12, 2006

Kevin Ryan, Administrator
Hillcrest Haven Convalescent Center
1071 Renee Avenue
Pocatello, ID 83201

Provider #: 135018

Dear Mr. Ryan:

On **June 16, 2006**, a Complaint Investigation was conducted at Hillcrest Haven Convalescent Center. Marcia Key, R.N. and Lisa Kaiser, R.N. conducted the complaint investigation. A total of 30 survey hours were required to complete this investigation. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00001499

ALLEGATION #1:

The complainant stated that an identified resident's family member brought in a heating pad. A certified nurse aide put the heating pad on the resident's feet and left it on all night long on the highest setting. Subsequently, the resident sustained third degree burns and her right foot was blistered and turning black.

FINDINGS:

Based on observations, review of the identified resident's Incident/Accident report, record review, and staff interview it was determined the facility failed to protect the resident from accident hazards resulting in second and third degree burns to the lower extremity.

The facility was cited at F323 and F314 which constituted immediate jeopardy for the resident. The facility was also cited at F225 at the harm level secondary to not thoroughly investigating the incident.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainant stated the facility did not transport the identified resident to the Emergency Room or call the doctor after she sustained second and third degree burns to her right lower extremity.

FINDINGS:

The identified resident's record was reviewed. It was determined the facility failed to keep the physician informed of the seriousness of the resident's lower extremity burns. Also, the facility failed to notify the physician or transport the resident on an emergent basis when she developed obvious cellulitis to the right lower extremity which required intravenous antibiotics and aggressive wound management.

The facility was cited at F323 at the level of jeopardy for failure to protect the identified resident from accident hazards, at F501 for failure to ensure medical supervision, assessment and management, and at F490 for failure to administrate the facility in a manner to maintain the highest practicable physical well-being of the identified resident. Both of these citations were at the level of harm.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #3:

The complainant stated the identified resident received poor pain control.

FINDINGS:

The identified resident's record revealed she was receiving inadequate pain management.

The facility was cited at F309 at the harm level for failure to adequately control the identified resident's pain.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the

Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Lorene Kayser

MARCIA KEY, R.N.
Health Facility Surveyor
Long Term Care

MK/dmj

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PHONE 208-334-6626
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CERTIFIED MAIL: 7000 1670 0011 3314 8866

June 30, 2006

Kevin Ryan, Administrator
Hillcrest Haven Convalescent Center
1071 Renee Avenue
Pocatello, ID 83201

Provider #: 135018

Dear Mr. Ryan:

On **June 16, 2006**, a Complaint Investigation survey was conducted at Hillcrest Haven Convalescent Center by this Bureau to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency in your facility to be **ISOLATED** deficiencies that constituted immediate jeopardy to resident health and safety. You were informed of the immediate jeopardy situations in writing on **June 16, 2006**.

On **June 16, 2006**, the facility submitted a credible allegation that the immediate jeopardy was corrected. After review of your Plan of Correction, it was determined that the immediate jeopardy to the resident had been removed. However, the deficiencies as identified on the revised CMS Form 2567L remain and require a Plan of Correction. The most serious deficiencies now constitute actual harm that is not immediate jeopardy and that is isolated in scope, as evidenced by the CMS Form 2567L, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in**

compliance. After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 13, 2006**. Failure to submit an acceptable PoC by **July 13, 2006**, may result in the imposition of additional civil monetary penalties by **August 2, 2006**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Based on the immediate jeopardy citations:

F314 -- S/S: J -- 483.25(c) -- Pressure Sores
F323 -- S/S: J -- 483.25(h)(1) -- Accidents

cited during this survey, we are recommending to the CMS Regional Office that the following remedies be imposed:

Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]

A 'per instance' civil money penalty of **$5,000.00**.
(*THIS REMEDY IS GENERALLY RESERVED FOR SITUATIONS OF SERIOUS NONCOMPLIANCE AS DESCRIBED AT §7510*) (§488.430)

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare &

Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 16, 2006**, if substantial compliance is not achieved by that time.

Your facility's noncompliance with the following:

F314 -- S/S: J -- 483.25(c) -- Pressure Sores,
F323 -- S/S: J -- 483.25(h)(1) -- Accidents

has been determined to constitute substandard quality of care as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR §488.325 (h) require that the attending physician of each resident who was found to have received substandard quality of care as well as the State board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

> The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:
>
> Residents # **#1** as identified on the enclosed Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of additional remedies.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf

This request must be received by **July 13, 2006**. If your request for informal dispute resolution is received after **July 13, 2006**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

STATE ACTIONS effective with the date of this letter (**June 30, 2006**):

Due to the serious nature of the deficiencies at **C789 and C790**, the Department is placing the facility on a **Provisional License**. Enclosed is Skilled Nursing Facility License #4. This license is effective through **December 30, 2006.** The conditions of the Provisional License are as follows:

1. Correction of all the deficiencies, including **C789, C790**.

2. The facility must obtain weekly consultation from a qualified professional nurse who is not an employee of the facility. The facility's choice of a consultant must be approved by the Department. The consultant must provide weekly reports to this office, indicating each deficient area has been reviewed, corrective actions taken, and the current status of each deficient area.

3. A ban on all admission is being placed on the facility, effective the date of this letter, in accordance with *Title 3, Chapter 12, Rules Governing Long Term Provider Remedies in Idaho*, Section 16.03.12.004.08, which allows additional remedies when non-compliance with program requirements is found.

   IDAPA Section 16.03.12.004.08., states:

   > 08. Ban on Admissions. Such bans to the facility or to any part thereof shall remain in effect until the State Survey Agency determines that the facility has achieved substantial compliance with all program requirements or until a substitute remedy is imposed.

Failure to comply with the conditions of the Provisional License may result in revocation of the facility's license. *IDAPA 16.03.02.003.05.a.* states:

a. Additional causes for denial of a license may include the following:

   I. The applicant has violated any conditions of a Provisional License.

Please be advised that you are entitled to request an administrative review regarding the issuance of the Provisional License. In order to be entitled to an administrative review, you must submit a written request to the State Survey Agency within fourteen (14) days from the date upon which you received this letter. The request must state the grounds for the facility's contention that Provisional License was inappropriate. Because a Provisional License may be issued whenever a facility is in substantial compliance with but does not meet every requirement or rule, during the review, you would be expected to demonstrate that none of the findings of deficiency were justified.

In any administrative review, you should be prepared to demonstrate that the Department's findings were in error.

You should also include any documentation or additional evidence that you wish to have reviewed as part of the administrative review. Your written request for administrative review should be addressed to, Randy May, Deputy Administrator, Division of Medicaid, 3232 Elder Street, PO Box 83720, Boise ID 83720-0036, Phone #: (208) 334-5747, Fax #: (208) 364-1811.

The rules and regulations governing the conduct of an administrative review are set forth at *IDAPA 16.05.03.300*. If you fail to timely request an administrative review, the Department's decision to impose remedies as set forth herein becomes final. Please note that issues, which are not raised at an administrative review, may not later be raised at higher level hearings (*IDAPA 16.05.03.301*).

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Loretta Todd

LORETTA TODD, R.N.
Supervisor
Long Term Care

LT/dmj

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135018	A. BUILDING _____ B. WING _____	C 06/16/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST HAVEN CONVALESCENT CTR	1071 RENEE AVE POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during a complaint investigation at the facility. The surveyors conducting the investigation survey were: Marcia Key, RN Team Coordinator Lisa Kaiser, RN Survey Definitions: MDS = Minimum Data Set assessment RAI = Resident Assessment Instrument RAP = Resident Assessment Protocol DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	F 000		

RECEIVED
JUL 10 2006
FACILITY STANDARDS

The facility changed Date B [illegible] To 7/13/06 Per letter dated 7/9/06 Marcia Key

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Jeanne Flynn | administrator | 7/7/06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 225	1.) A more thorough investigation of this incident was completed while the surveyors were in the facility. We do not feel this resident was abused or neglected. She requested to use a electrical heating pad which she had used in the past and provided her with relief. 2.) Prior incidents reports were pulled and reviewed to ensure accuracy and completeness. (30) days prior to July 3, 2006. 3.) Inservices on the proper way to complete an incident report will be given to staff on a monthly basis. 4.) Incident reports will be monitored by the DNS and the Administrator to ensure accuracy and completeness. Incidents involving abuse will be reported to the Bureau of Facility Standards and when appropriate the local authorities. All efforts will be made to ensure the resident is not subject to neglect or abuse while the investigation is in progress. 7/20/06 The answers given to the stated deficiencie are not an admission of guilt and therefore cannot be used against this facility in a court of law. These answers are required in order to comply with the rules and regulations of the Medicaid and Medicare Programs.	

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F 225	Continued From page 2 by: Based on staff interviews, record review, and a complaint from the public, it was determined the facility failed to thoroughly investigate an incident regarding a specific resident to rule out abuse or neglect. This affected 1 of 1 (#1) sample residents. Resident #1 sustained 2nd and 3rd degree thermal burns to her right heel and lower extremity on 5/18/06 from a heating pad placed on or near her feet and ankles by staff resulting in harm to the resident. Facility administrative staff signed off on the incident investigation report on 5/18/06 before the incident was thoroughly investigated. Findings include: Resident #1 was admitted to the facility on 4/12/06 with diagnoses including history of cerebral vascular accident, osteoarthritis, vascular dementia, neuropathy, dysphagia, edema, leg pain, paraparesis and low back pain. A handwritten inventory list, attached to facility's "Clothing And Valuable List," dated 4/22/06, documented "...(1) Heating pad..." A "Resident Incident/Unusual Occurrence Report," dated 5/18/06 at 7:20 am, documented two CNAs entered the resident's room to get her up and discovered a heating pad "...between her heels." The report documented the CNAs "...observed some redness on the Right heel..." and notified a nurse immediately. The second page of the incident report, under "****For Administration Use Only****" contained a section identified as "Employee interview:" and one identified as "Bureau of Facility Standards Notified? Y N." Both sections had room for	F 225	The answers given to the stated deficiencie are not an admission of guilt and therefore cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare program.	

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F 225	Continued From page 3 documentation regarding the above-mentioned topics. Both sections were blank for this incident investigation. Attached to the incident report was an "Incident Report Investigation, " dated 5/18/06. The investigation report included the following information: "...This morning at 0720 [7:20 am], 2 CNAs went into [resident #1's] room to assist her with preparations for the day. As they pulled the blankets down, they noticed a heating pad on her feet, between the heels. When they removed the heating pad, some redness was noted on the right heel...Upon investigating the incident, it was determined that the family had brought in the heating pad for the resident. The heating pad was placed on her feet at 0600 [6:00 am]. The staff had just assisted her with toileting at 0600. The resident had been physically viewed 5 minutes prior when she was noted to be resting. Family and physician were notified. I interviewed and spoke with the staff that worked that night, inservicing them on the policy that we do not utilize any heating pads in the facility. Family were notified and the heating pad was removed from the building." The resident's nursing notes were reviewed. The documentation revealed an entry dated 5/18/06 at 3:30 pm that stated, "Res[ident] family brought heating pad in from other facility, res requested heating pad to be put on. Nursing staff was unaware of heating pad was in RM [room]. Aids [sic] found heating pad, put on Res feet, when arriving to work for shift, observed Res [with] 2 blisters on feet, notified family [and] MD [medical	F 225	The answers to the stated deficiencies are not an admission of guilt and therefore cannot be used against this facility in a court of law. They are required by al the Medicaid and Medicare programs.	

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F 225	Continued From page 4 doctor], Son has stated he was going to take pad home." The DON was interviewed on 6/15/06 at 3:50 pm, regarding the incident of 5/18/06. She stated, "...the CNAs found the heating pad on [resident #1] at 0600...it had been on all night...the family brought the heating pad in that day..."The DON stated that nobody had admitted to placing the heating pad on the resident initially and that the resident had been "...toileted twice..." during the night and nobody remembered seeing the heating pad. She stated, "...at some time during the night, someone placed the heating pad on her chest.." At 6:00 am, staff put the heating pad between the resident's heels. The DON acknowledged she had not interviewed the staff who worked the evening shift on 5/17/06 regarding who may have placed the heating pad on the resident initially. She could not offer any information regarding how the resident could have been toileted twice during the night and nobody noticed a heating pad on or near her body. On 6/15/06, at the request of the surveyors, the DON began to telephone staff members to gain more information regarding the incident. Staff members who were scheduled to work were able to write statements and the DON recorded information from staff she spoke with on the telephone. The LN on duty on 5/18/06, wrote a statement on 6/15/06. The LN noted that when she arrived in the resident's room, she observed "...a heating pad under her [resident #1] R [right] foot and ankle..." Upon assessing the right leg, the LN noted "...a red area on the heel and bottom of foot, when I pressed the skin around the red area it blanched..." The LN documented that she had	F 225	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	

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F 225	Continued From page 5 provided basic first aid for the reddened area and applied a brace to the resident's foot. The LN documented, "...At 0930 [9:30 am] the aid [sic] came and got me once again to look at the ankle. At this time, I unwrapped the foot and I observed the ankle having a blister on it and the red area on the heel and bottom of foot was blistered. I then got two clean/new non-adhesive pads and two clean/new rolls of curlex [sic] and re-wrapped the ankle and foot and put the AFO [ankle-foot orthoses] brace back on." On 6/15/06, the DON spoke with a night shift LN who worked on 5/18/06. She documented the following: "Med[icated] [resident #1] [at] 0430 [4:30 am] for pain when he was notified by CNA that she was c/o [complaining of] pain in lower extremities. Had no knowledge of a heating pad on Res. [resident] [at] any time until he came to work the next noc [night] [after] incident." On 6/15/06, the DON spoke with an NA who worked the night shift on 5/18/06 and documented the following: "Stated he saw the heating pad on her chest on 1st Rounds [at] 2300 [11:00 pm]. She was checked for bathroom need at 0100 [1:00 am] 0300 [3 am] [and] also repositioned. Unclear as to when the pad was placed on her [lower] legs [and] ankles but notified the nurse [at] the time that she was c/o [lower] leg/feet pain. [NA's name] said that he thought the heating pad had 4 settings [and] she asked him to turn it up. He thought he set it on the 2nd or 3rd setting. Recalled that the heating pad was white [with] a white cover." The facility failed to thoroughly investigate an incident in which a resident sustained thermal	F 225	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	

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F 225	Continued From page 6 burns. The incident report did not mention the fact that staff observed the heating pad on the resident's chest at approximately 11:00 pm in the evening of 5/17/06, why staff did not notice the heating pad was on or near the resident when she was toileted at 1:00 am and 3:00 am, what setting the heating pad was on when it was found between the resident's heels, or if staff had used the heating pad on the resident before this incident. The DON noted that the heating pad had been removed from the facility by the family and that facility staff had not examined it for defectiveness or a possible malfunction. The DON acknowledged that she had not interviewed all the staff who worked in the facility during that time period. She did not interview any of the evening shift staff who worked on 5/17/06 when the resident was put to bed. The DON obtained written statements and conducted telephone interviews at the surveyors' request during the complaint investigation to gain more information regarding the incident.	F 225	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	
F 309 SS=G	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record	F 309	1.) The resident was admitted to the emergency room and we received orders to treat the wound, the infection and have a follow up consultation with the attending physician. In addition a Certified Wound Care Specialist has been hired as a consultant and has treated and dressed the wound appropriately. The care plan has been updated to reflect the changes in the residents condition and what we are doing to ensure she reaches her highest practical level of functioning. Our pain management program is being	

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F 309	Continued From page 7 review, and a complaint from the general public, it was determined the facility failed to ensure a resident was provided an initial evaluation and ongoing medical assessments by a physician after sustaining burns. This deficient practice resulted in physical and psychosocial harm to 1 of 1 sample residents (#1). Resident #1 sustained thermal burns to the right medial heel and right medial lower extremity on 5/17/06 or 5/18/06. The resident experienced increasing pain over the course of the next 27 days. Findings include: Resident #1 was admitted to the facility on 4/12/06 with diagnoses including history of cerebral vascular accident, osteoarthritis, vascular dementia, neuropathy, dysphagia, edema, leg pain, paraparesis and low back pain. Upon admission on 4/12/06, the resident was prescribed the following medications for pain: Ultram 50 mg (milligrams) 4 times per day as needed. She was also prescribed Neurontin 400 mg four times per day for seizures. The resident's MAR for May 2006 documented a Fentanyl 25 mcg [micrograms] patch had been initiated on 5/8/06. Physician telephone orders revealed the following: *5/23/06 - "PT [physical therapy] to eval[uate] & treat..." *5/31/06 - "Give [two] 325 mg Tylenol now. For pain." *6/7/06 - "Fentanyl patch 25 mcg [change] q	F 309	rewritten to ensure any resident suffering from pain is monitored closely, and if the pain is not releived after following the current physician orders, the physician is notified and new orders are obtained. The care plan and the treatment plans will reflect the current physician orders. If the attending physician does not change a treatment plan that is not having the intended effect our Medical Director will be notified and asked to consult with the attending physician. If this is ineffectiv the resident and or their responsible party will be consulted and asked if they would like to change attending physicians. Physicians will be notified of all changes in conditions of their patients. 2.) All patients in this facility had a new skin assessment completed by our DNS on 6-19-06. Changes in the care plans have been made to reflect the current condition. 3.) Our pain management policy has been rewritten, and inservices are being given to our staff to inform them of this new policy. In addition inservices are being held regarding, our skin care program and dressing changes. 4.) Our DNS and our QA committee will monitor these programs to ensure our nursing staff are following our policies Regarding: physician notification, Skin care and pain management. 7-20-06	

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F 309	Continued From page 8 [every] 3 days for pain." *6/11/06 - [Change] Ultracet to [two] tabs[tablets] Q [every] 4-6 hours prn [as needed] x [times] 48 [hours], call [resident's physician] [after] that [with] comfort level." *6/12/06 "dc [discontinue] ultracet/ - vicodin 5 QID [four times per day] PRN for breakthrough pain. - [change] duragesic patch to 50 mcg." The "Pain Assessment" form dated 5/12/06, documented the resident had "chronic" pain in her "...[right] heel/bilateral heel..." due to a "decubiti/ulceration." In the "Severity" portion of the assessment form the resident's pain scale was documented as 8 to 9 and non-verbal indicators present were documented as "crying, grimacing, moaning...retracts legs." The assessment documented that a Fentanyl patch was started on 5/8/06 and that Vicodin 5/500 mg helped to relieve the pain. A "Resident Incident/Unusual Occurrence Report," dated 5/18/06 at 7:20 am, documented two CNAs had entered the resident's room to get her out of bed and discovered a heating pad "...between her heels." The report documented the CNAs "...observed some redness on the Right heel..." and notified a nurse immediately. The resident's nursing notes revealed an entry dated 5/18/06 at 3:30 pm that stated, "Res[ident] family brought heating pad in from other facility, res[ident] requested heating pad to be put on. Nursing staff was unaware of heating pad was in RM [room]. Aids [sic] found heating pad, put on Res feet, when arriving to work for shift, observed	F 309	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	

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F 309	Continued From page 9 Res [with] 2 blisters on feet, notified family [and] MD [medical doctor]..." During the complaint investigation, at the request of the surveyors, the LN on duty on 5/18/06, wrote a statement on 6/15/06. The LN noted that when she arrived in the resident's room, she observed "...a heating pad under her [resident #1] R [right] foot and ankle..." Upon assessing the right leg, the LN noted "...a red area on the heel and bottom of foot, when I pressed the skin around the red area it blanched..." The LN documented that she had provided basic first aid for the reddened area and applied a brace to the resident's foot. The LN documented, "...At 0930 [9:30 am] the aid [sic] came and got me once again to look at the ankle. At this time, I unwrapped the foot and I observed the ankle having a blister on it and the red area on the heel and bottom of foot was blistered. I then got two clean/new non-adhesive pads and two clean/new rolls of curlex [sic] and re-wrapped the ankle and foot and put the AFO [ankle-foot orthoses] brace back on." The resident's nursing notes from 4/12/06 to 5/18/06, documented issues regarding pain as well as occurrences of the resident crying out for help shortly after admission to the facility. Nursing notes from 5/18/06 through 6/15/06 documented the following: *5/18/06, 11:00 pm - "...yelling out 'help me, help me' medicated per physician's orders, large blister [right] heel [without] drainage..." *5/19/06, 9:30 pm - "Dressings to feet & legs dry	F 309	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by th the Medicaid and Medicare programs.	

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F 309	Continued From page 10 and intact." Fairly quiet. C/O [complains of] pain medicated x1 [with] Ultram..." *5/20/06, 3:00 pm - "0730 [7:30 am] Yelling out 'help me help me, won't somebody help me' when asked what she needed she had a wide array of general complaints - Ultram given. Repositioned..." *5/21/06, 9:30 pm - "Blister open, dressing wet from clear drainage, re-wrapped [at] 1730 [5:30 pm] [1] pain pill given, verbally negative statements, [no] success [with] redirection. Seems more pleasant when in recliner..." *5/22/06, 2:00 pm - "Dressing to blister clean dry & intact. Given Ultram for pain. Uneffective - called physician to see if something stronger could be ordered. Still awaiting call back from physician. Will continue to monitor." *5/22/06, 3 pm to 11 pm shift - "Demanding et [and] combative - Denies any cares offered. Phys [physician] returned call refused stronger Pain med. Suggest pain specialist appointment..." *5/30/06, 10 pm - "Fentanyl 25 mcg patch [changed] and Ultram given, for c/o [right] foot and back pain...[Name of pain specialist] was attempted per phone for pain consult. Their office was closed. Therefore, will need to set-up appt. [appointment] tomorrow." *5/31/06, 10 pm - "Res[ident] yelling out frequently. Res given TLC [tender loving care] on call light frequently call light answered promptly. Res wants boots off feet. Res medicated for pain x2 #7 [on pain scale]...some relief noted 30	F 309	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	

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F 309	Continued From page 11 min[utes] later. Then Res c/o foot pain Ultram given [at] 2100 [9 pm] ineffective. Res continue to c/o pain state[s] it is a #10 [on pain scale] and can't get relief. Family requesting [pain specialist] be contacted tomorrow [unable to read word] have appointment set up for Res." *6/3/06, 9 pm - "Res c/o of pain in feet. Ultram...given [with] fair results gave TLC..." *6/7/06, 9:30 am - "Call to [resident's personal physician] regarding increased pain in feet...message left." *6/7/06, 3:00 pm - "Message left [with] MD office R/T [related to] pt's [patient's] increased pain, Ultram & Fentanyl patch not effective, requested [change] in pain medication." *6/8/06, 3:00 pm - "[Resident #1] has been calling out for help most of the day despite all efforts to help her - repositioning, chair to bed, bed [to] chair, leg [up], leg [down], medicated x2 w/ [with] Ultram. Helpful for short time." *6/8/06, no time noted - "...Ultram [one] PO [by mouth] given at 2130 [9:30 pm] c/o pain eff[ective] in 30 min[utes]... *6/10/06, 5:30 am - "Medicated [with] Ultram tab [one] po [by mouth] for c/o foot pain. Has continued calling out for help [without] let up. Reposition for comfort, given water. Asked what staff can do for resident to help her but resident unable to tell staff what she needs to help her." *6/10/06, 3:00 pm - "I have noticed over the last couple of weeks that [resident #1] seems to have	F 309	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	

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F 309	Continued From page 12 a more difficult time in the mornings - more calling out for help & being inconsolable - after lunch she appears calmer..." *6/11/06, 3 pm to 11 pm shift - "Med[ication] [increased] to [two] for pain this shift - con't [continues] to c/o "I need help" & "Why don't you help" even while NS [nursing staff] is sitting beside her feeding her." *6/12/06, 10:51 am - "Medicated as ordered Res cont[inued] to call out for help..." *6/12/06, 3:00 pm - "Med[ication] [change], Ultram d'cd [discontinued], Fentanil [sic] patch [increased] to 50 mcg, Vicodin 5 prn for breakthrough pain. Pt calling 'help me' when approached states 'you can't help me' visit 1:1 [one on one] with [resident #1] and she seems to calm down and no longer needs help." *6/13/06, 10 pm - "[Resident #1] calling for 'help' most of this shift (3-11) when asked what she needed [resident #1] replies 'I don't know, I need help' unable to communicate what she needs or wants, if 1:1 with [resident #1] for 5-10 min[utes] she calms down and stops asking for help." *6/14/06, 2:15 pm - "Res requested pain med, [unable to read word] given [at] 1000 [10 am] 8/10 [on pain scale] effective 30 min later but [not] kept pain managed for long. Requested pain meds again [at] 1300 [1 pm] Called MD for alt[ernate] or another pain med, [no] answer, will call back." *6/15/06, 2:00 pm - "Called MD R/T pain management...waiting for call back..."	F 309	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare program.	

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F 309	Continued From page 13 On 6/15/06 at approximately 3:00 pm, the surveyors observed the resident's right leg and foot during a dressing change to wounds on her heel and lower extremity. The resident was sitting in a reclined position. She had bilateral heel protectors on. The right lower extremity had a Kerlix wrap which extended beyond the heel protector. The exposed area of her anterior lower extremity, beyond the Kerlix wrap, was noted to be very red, taut and edematous. This area was approximately 20 centimeters (cms) above the ankle region. The LN removed the heel protector and the dressings. As the LN was removing the Kerlix wrap a faint foul odor was emitted from the area of the wound. The surveyor was standing approximately 5 feet from the resident's lower extremity. As the surveyor leaned within 2 - 3 feet of the wound, the odor was more apparent. The following was observed: The resident's medial right heel was covered by firmly attached black, dry eschar, measuring 4.0 x 4.5 -5.0 cms. The immediate surrounding skin was deep red, measuring 4.5 cms inferiorly, 1.0 cm medially, and 2.5 cms superiorly to the eschar margins. There was a second wound along the resident's medial lower extremity, approximately 3.6 to 4.8 cms above the heel eschar. This wound was irregularly shaped and measured approximately 3.5 x 4.0 cms. The wound bed was covered with 50 - 60% pale yellow mucoid tissue. The remainder of the wound bed contained pink granulating tissue. The immediate surrounding skin was deep red, measuring from 0.5 - 1.0 cm along the inferolateral wound margins, to 2.0 - 4.5 cms along the superolateral wound margins. The anterior lower extremity intact skin was described previously.	F 309	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	

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F 309	Continued From page 14 During the dressing change, the resident remained in her recliner with her son at her side. Throughout the procedure, the resident moaned and writhed in pain, at times telling the LN to "hurry up" and finish the dressing change. Her son attempted to comfort her throughout the procedure but was unsuccessful. At one point during the dressing change as the resident was crying out in pain, the LN stated, "...I know [resident #1], I'll hurry so I can get you some pain medication..." The resident stated, "You should have given me my pain medicine before you started this..." After the dressing change, the resident was assisted back to her bed by 2 staff members and at approximately 3:20 pm, the LN left the room to get the resident's pain medication. An interview was conducted with the DON on 6/15/06 at 3:50 pm regarding the injuries sustained by the resident. When questioned about whether or not anyone from the facility had been contacting the physician regarding the condition of the resident's wounds she stated, "I don't know if he [the physical therapist] did or we did...In many ways we rely on our physical therapy department..." The DON reviewed the resident's record and could find no indication that a physician had examined the resident's right lower extremity and heel since she sustained the thermal burns on 5/17 or 5/18/06. The DON acknowledged that she herself had not assessed the resident's thermal burns and stated she first observed them "...exactly when you saw them..." She stated she relied on the nursing notes to keep her informed as to the resident's situation. The DON and Assistant Administrator were	F 309	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	

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F 309	Continued From page 15 interviewed on 6/15/06 at approximately 7:30 pm regarding the resident's burns and pain issues. The Assistant Administrator stated the resident was scheduled to see the pain specialist "next week" for an initial evaluation. The administrative staff were questioned about the delay in obtaining orders from the physician for pain medication for the resident and the lack of follow up by the nursing staff. The DON could offer no written policy or information regarding how long the nursing staff was expected to wait to receive a call back from a doctor regarding situations such as inadequate pain management or at what time it was appropriate to involve the facility's medical director. The facility's inadequate management of the resident's increasing physical pain resulted in harm to the resident. From the day of admission on 4/12/06, the resident suffered from chronic pain which was exacerbated by thermal burns to her right lower extremity and heel sustained on 5/17 or 5/18 and a pressure ulcer to her right heel. Nursing notes documented the resident's struggle with pain and her history of crying out for help. Even after the resident's physician ordered an evaluation by a pain specialist on 5/22/06, the facility did not get an appointment scheduled until 6/21/06, nearly a month after the initial order. Nursing notes documented the resident's pain level was often a 7 or higher on the pain scale and if medication relieved the pain, it was often only for a short time. During a dressing change on 6/15/06, the resident made a point of noting that she should have received pain medication before the dressing change began. The facility did not ensure the resident received	F 309	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	

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F 309	Continued From page 16 an assessment by a medical doctor and ongoing medical treatment after she sustained the thermal burns. A physician did not evaluate the resident's burns until 6/15/06, nearly a month after she initially sustained the burns, when the surveyors called immediate jeopardy and the resident was taken to a local emergency room. Upon evaluation at the emergency room, the resident was diagnosed with cellulitis and was started on intravenous antibiotics. The emergency room physician noted the resident was to see her regular physician within 3 days and was to begin "...aggressive physical therapy for debridement of [right] ankle..." The resident was subsequently diagnosed with MRSA (Methicillin resistant Staphylococcus aureus) infection in her wound and required aggressive treatment with antibiotics as well as a referral to a wound specialist.	F 309	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	
F 314 SS=J	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record reviews, and a complaint from the public, it was determined the facility failed to ensure a resident	F 314	1.) We hired a Certified Wound Care Specialist to assist in the following areas: A.) Review our current wound care policies and procedures and revise them as needed. B.) Oversee the wound care treatment in this facility. C.) Provide inservices to our staff on an ongoing basis regarding our wound care program and appropriate wound care techniques. 2.) The care plan and plan of treatment for this resident has been rewritten to	

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F 314	Continued From page 17 did not develop a pressure ulcer while in the facility. This failed practice resulted in serious harm, constituting immediate jeopardy to 1 of 1 (#1) sampled residents who sustained a large unstageable pressure ulcer to her right medial heel. The facility could provide no documentation as to the circumstance of when the heel ulcer actually developed in the facility or that the heel was evaluated. The facility failed to implement appropriate management or appropriate interventions to prevent further deterioration. The facility also failed to notify the resident's physician after the unstageable pressure ulcer was first observed by the staff. The right heel and lower extremity became infected as a result of this failed practice. The resident sustained second and third degree burns to the site which contributed to the infection. This failed practice was brought to the attention of the facility's Administrator, DON, and Assistant Administrator on 6/16/06, at 10:00 am. These staff were provided with specific details of the failure to ensure the resident did not develop a pressure ulcer. On 6/16/06 at 1:40 pm, the facility presented the surveyors with an acceptable plan of correction and the immediate jeopardy was abated. The plan of correction was as follows: "We will hire a CWCN [Certified Wound Care Nurse] on a consultant basis to perform the following for this facility: 1.) A CWCN or Certified wound care Specialist [CWS] shall be in the facility no later than 6/21/06	F 314	ensure she is receiving the proper treatment as ordered by her attending physician to heal the wound and protect her from developing any additional skin problems. 3.) Our DNS has completed skin assessments on every patient in thi facility and the care plans have been updated where needed (copies of these assessments were faxed to the surveyors) 4.) Skin assessments will be performed by our licensed staff and appropriate care plans will be developed based on these assessments. These assessments will be completed on the following schedules: A.) Upon admission B.) If there are no skin care problems licensed staff will complete assessments weekly. C.) If upon completion of the initial skin assessment there is impairment in the skin integrity, licensed staff will notify the attending physician, the residents family and the Certified Wound Care Specialist. Orders for treatment, and a plan of treatment will be developed and the treatement will begin immediately. D.) A nutritional assessment will be completed upon each admission. Physicians of residents who suffer from skin impairment will be notified and supplements will be ordered taking into account the residents	

The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and medicare programs.

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	135018	A. BUILDING _____ B. WING _____	C 06/16/2006

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F 314	Continued From page 18 at 7:00 am. 2.) In order to ensure no other residents are effected our Director of Nursing and one other RN is also completing head to toe skin assessments on every resident curretnly [sic] in our facility and will fax these to the surveyor on Monday, 6/19/06, by 2:00 pm. 3.) Review our current wound care policies and procedures including treatment and prevention and revise these policies where necessary. To ensure this does not occur again. 4.) Oversee treatments of wounds on patients in this facility. 5.) Provide inservices education to our staff on a ongoing basis regarding our wound care program and appropriate wound care techniques. Skin assessments will be performed by our licensed staff and appropriate care plans will be developed based on these assessment. These assessments will be completed on the following schedules. 1.) Upon admission. 2.) If there are no skin care problems licensed staff will complete assessment weekly. 3.) If, upon completion of the initial skin assessment there is impairment in the skin integrity, licensed staff will notify the attending physician, the residents family and the CWCN or CWS consultant. Orders for treatment and the plan of treatment will be obtained and treatment	F 314	total condition. Additional dietary assessments will be completed on a monthly basis for those residents suffering from skin impairment. 7-20-06 E.) This will be monitored by our DNS, Dietary Supervisor, and our QA Nurse. The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	

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F 314	Continued From page 19 will begin. 4.) A nutritional assessment will be completed upon each admission. Physicians of residents who suffer from skin impairment will be notified and supplements will be ordered taking into accounts the Residents total condition. Additional dietary assessment will be completed on a monthly basis for those residents suffering from skin impairment. Date [to be] completed 6/23/06." Findings include: Resident #1 was admitted to the facility on 4/12/06 with diagnoses including history of cerebral vascular accident, osteoarthritis, vascular dementia, neuropathy, dysphagia, edema, leg pain, paraparesis, low back pain and pressure ulcer to the buttock region. The complaint team entered the facility on 6/15/06 at 2:45 pm, in order to investigate an allegation that resident #1 had sustained second and third degree burns as a result of the facility's use of a heating pad. The complaint team asked for the resident's chart and requested the DON to accompany the two surveyors to resident #1's room in order to visualize the resident's right lower extremity. The DON, the charge LN, and a physical therapy assistant entered the resident's room with the surveyors. The resident was sitting in her recliner. Her son was also present. The resident was sitting in a reclined position. She was wearing bilateral heel protectors. The right lower extremity had a Kerlix wrap which extended beyond the heel protector. The exposed	F 314	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare program.	

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F 314	Continued From page 20 area of her anterior lower extremity, beyond the Kerlix wrap, was noted to be very red, taut and edematous. This area was approximately 20 centimeters (cms) above the ankle region. The LN removed the heel protector and the dressings. As the LN was removing the Kerlix wrap a faint foul odor was emitted from the area of the wound. The surveyor was standing approximately 5 feet from the resident's lower extremity. As the surveyor leaned within 2 - 3 feet of the wound, the odor was more apparent. The following was observed: The resident's medial right heel was covered by firmly attached black, dry eschar, measuring 4.0 x 4.5 -5.0 cms. The immediate surrounding skin was deep red, measuring 4.5 cms inferiorly, 1.0 cm medially, and 2.5 cms superiorly to the eschar margins. There was a second wound along the resident's medial lower extremity, approximately 3.6 to 4.8 cms above the heel eschar. This wound was irregularly shaped and measured approximately 3.5 x 4.0 cms. The wound bed was covered with 50 - 60% pale yellow mucoid tissue. The remainder of the wound bed contained pink granulating tissue. The immediate surrounding skin was deep red, measuring from 0.5 - 1.0 cm along the inferolateral wound margins, to 2.0 - 4.5 cms along the superolateral wound margins. The anterior lower extremity intact skin was described previously. After viewing the resident's right lower extremity wounds, the survey team asked to speak with the Administrator, the assistant Administrator and the DON at 4:30 pm. During the interview the Administrator indicated that the resident was admitted to the facility with a "black cap" on her	F 314	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare program.	

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F 314	Continued From page 21 right heel and that the physical therapist could verify that the "black cap" on the resident's heel was still present at the time the resident sustained the burn on the heel from the heating pad. The surveyor spoke to the physical therapist via telephone at 4:44 pm. The therapist indicated the resident was admitted to the facility with a black heel. The therapist also indicated that an LN asked him to assess the heel. He recalled he instructed the staff to keep the area dry and not attempt to remove the black eschar. He stated he was not sure if he documented his assessment. When he saw the thermal injuries, he noticed there was a blister on top of the original eschar. Once the blister opened the original black eschar was again observed. He also stated the therapy department had photographs of the wounds since they initiated treatment on 5/24/06. He stated the first photograph taken 5/24/06 showed the original heel eschar. He agreed to produce color copies of the right heel and lower extremity wounds for the surveyors. The physical therapy notes were reviewed for 5/24/06 and documented the following: "...The heel wound is 7.3 cm x 6 cm. It is important to note that the heel wound necrosis in the center is from the previous pressure ulcer and not from the burn (she had a [sic] intact heel cap previously)". The resident's admission nursing assessment, dated, 4/12/06, was reviewed by the DON and the surveyors. The Comprehensive Skin Assessment section, also dated 4/12/06, identified the following: "Bruises Bil[ateral] areas front [word not legible] - rt [right] hand swollen & bruised - Bruise bil leg posterior & anterior - 4 cm open area on lt	F 314	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	

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F 314	Continued From page 22 [left] inner buttock [words not legible] cream apply - nail lt foot [word not legible] 4th & 5th toe on medial side of 5th toe 2 inches long 1/8 deep...Bil heel protectors on." The body diagram on the form identified the multiple upper and lower extremity bruising and the open area to the right buttock region. There was no identified injury to the resident's right heel. The admission nurses' notes, dated 4/12/06, also identified the above skin issues. There was no mention of a right heel injury. The physical therapist came to the facility 6/15/06 and was interviewed by the two surveyors at 6:10 pm. He stated he had attempted to locate his assessment notes for the time period when he evaluated the resident's heel. "I didn't see her when she first came in. I can't find my notes." He stated he was certain the resident had black eschar on her right heel prior to the thermal injury to the site. He acknowledged he was not sure if she was admitted to the facility with the pressure ulcer. The surveyors reviewed the Daily CNA Skin Check Sheet. The documentation identified from 4/13/06 through 5/18/06 that the resident had no impaired skin. This documentation contradicted the initial nursing assessment as identified earlier. The Skin Problem Assessment Flow Sheet was initiated on 5/18/06, the day the thermal injuries were sustained. The right heel was described as a "blister burn" and the color was "purple." There was no documentation prior to 5/18/06 that identified the resident had black eschar on the right heel.	F 314	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	

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F 314	Continued From page 23 There was no physician notification after the physical therapist became alerted by an LN that the resident had developed an unstageable pressure ulcer. There was no immediate care plan initiated to direct the staff how to protect the heel from further pressure and to protect other vulnerable areas prone to increased pressure. The facility failed to assess, monitor and treat a large black eschar to the resident's right heel that developed after she was admitted to the facility. This failed practice resulted in immediate jeopardy.	F 314	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	
F 323 SS=J	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff and family interviews, record review, and a complaint from the public it was determined the facility failed to ensure a resident's environment remained free of accident hazards as possible. This failed practice resulted in serious harm, constituting immediate jeopardy to 1 of 1 (#1) sample residents. A heating pad was placed on or near the resident's feet and lower extremities causing thermal burns at the 2nd and 3rd degree level. The resident sustained thermal burns to the right medial heel and right medial lower extremity on 5/17/06 or 5/18/06. The resident experienced increasing pain over the course of the next 27 days. The	F 323	Each resident at the facility will be assured their environment is as free of hazards as possible. 1.) The heating pad has been removed from the facility. 2.) The rooms of all other residents have been thoroughly checked to ensure there are no other heating pads in our facility. 3.) Signs have been posted in the facility indicating the use of heating pads is prohibited. We have added language to our admission agreement indicating the use of heating pads is prohibited, we have sent out a notice to all families informing them of our policy regarding heating pads. We will provide quarterly inservices to remind staff of our policy regarding heating pads. Staff and memebers of the QA committee will monitor the facility for heating pads during their QA rounds and unit cleans.	

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F 323	Continued From page 24 facility could provide no documentation that the resident had an initial evaluation and ongoing medical assessments by a physician since sustaining the burns. The facility failed to thoroughly investigate the circumstances surrounding this incident. This failed practice was brought to the attention of the facility's Administrator, DON, and Assistant Administrator on 6/15/06, at 4:30 pm and the facility was provided with specific details of the failure to ensure the resident's environment remained free of accident hazards. At this time, the Administrator indicated heating pads were not allowed in the facility. Idaho state rules prohibit portable heating devices in long-term care facilities. Prior to submitting an acceptable plan of correction, the surveyors were informed that the resident had been transported to a local emergency room at approximately 4:45 pm on 6/15/06. On 6/15/06, at approximately 8:45 pm, the facility presented the surveyors with an acceptable plan of correction and the immediate jeopardy was abated. The plan of correction was as follows: "Each resident at the facility will be assured an environment free of hazards. All resident rooms have been searched for any heating pads that may be in their rooms and removed. Signs will be made and posted throughout the facility as to the policy of Hillcrest which is there is [sic] no heating	F 323	4.) This will be monitored by our DNS, Administrator, and our Inservice Director. 7-20-06 The answers to the stated deficiencies are not an admission fo guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	

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F 323	Continued From page 25 pads allowed in the facility for resident use. We will add language to our admission agreement stating that this facility does not allow the use of heating pads. We will also make a notation on our resident inventory list that heating pads are not allowed. The facility will also send a notice out to all residents and their interested parties informing them of the policy of not utilizing heating pads in this facility. The facility will provide quarterly inservices to staff to re-educate and remind them of the policy. Staff will monitor rooms for heating pads during their quality assurance rounds and during the unit cleans which are scheduled bi-monthly. As noted in the statement the facility did transport this resident to the emergency room this afternoon for evaluation by a physician. Corrective Actions will be completed by 6/23/2006." The facility presented the surveyors with a written statement, signed by a staff member, dated 6/15/06 at 4:00 pm, that stated the following: "I checked rooms for heating pads per your request, none were found..." Findings include: Resident #1 was admitted to the facility on 4/12/06 with diagnoses including history of cerebral vascular accident, osteoarthritis, vascular dementia, neuropathy, dysphagia, edema, leg pain, paraparesis and low back pain. A handwritten inventory list, attached to facility's "Clothing And Valuable List," dated 4/22/06, documented "...(1) Heating pad..." A "Resident Incident/Unusual Occurrence	F 323	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	

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F 323	Continued From page 26 Report," dated 5/18/06 at 7:20 am, documented two CNAs had entered the resident's room to get her up and discovered a heating pad "...between her heels." The report documented the CNAs "...observed some redness on the Right heel..." and notified a nurse immediately. Attached to the incident report was an "Incident Report Investigation, " dated 5/18/06. The investigation report included the following information: "...This morning at 0720 [7:20 am], 2 CNAs went into [resident #1's] room to assist her with preparations for the day. As they pulled the blankets down, they noticed a heating pad on her feet, between the heels. When they removed the heating pad, some redness was noted on the right heel...Upon investigating the incident, it was determined that the family had brought in the heating pad for the resident. The heating pad was placed on her feet at 0600 [6:00 am]. The staff had just assisted her with toileting at 0600. The resident had been physically viewed 5 minutes prior when she was noted to be resting. Family and physician were notified. I interviewed and spoke with the staff that worked that night, inservicing them on the policy that we do not utilize any heating pads in the facility. Family were notified and the heating pad was removed from the building." The resident's nursing notes were reviewed. The documentation revealed an entry dated 5/18/06 at 3:30 pm that stated, "Res[ident] family brought heating pad in from other facility, res requested heating pad to be put on. Nursing staff was unaware of heating pad was in RM [room]. Aids	F 323	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by law the Medicaid and Medicare programs.	

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F 323	Continued From page 27 [sic] found heating pad, put on Res feet, when arriving to work for shift, observed Res [with] 2 blisters on feet, notified family [and] MD [medical doctor], Son has stated he was going to take pad home." At the request of the surveyors, the LN on duty on 5/18/06, wrote a statement on 6/15/06. The LN noted that when she arrived in the resident's room, she observed "...a heating pad under her [resident #1] R [right] foot and ankle..." Upon assessing the right leg, the LN noted "...a red area on the heel and bottom of foot, when I pressed the skin around the red area it blanched..." The LN documented that she had provided basic first aid for the reddened area and applied a brace to the resident's foot. The LN documented, "...At 0930 [9:30 am] the aid [sic] came and got me once again to look at the ankle. At this time, I unwrapped the foot and I observed the ankle having a blister on it and the red area on the heel and bottom of foot was blistered. I then got two clean/new non-adhesive pads and two clean/new rolls of curlex [sic] and re-wrapped the ankle and foot and put the AFO [ankle-foot orthoses] brace back on." On 6/15/06, the DON spoke with a night shift LN who worked on 5/18/06 and documented the following: "Med[icated] [resident #1] [at] 0430 [4:30 am] for pain when he was notified by CNA that she was c/o [complaining of] pain in lower extremities. Had no knowledge of a heating pad on Res. [resident] [at] any time until he came to work the next noc [night] [after] incident." On 6/15/06, the DON spoke with an NA who worked the night shift on 5/18/06 and	F 323	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	

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F 323	Continued From page 28 documented the following: "Stated he saw the heating pad on her chest on 1st Rounds [at] 2300 [11:00 pm]. She was checked for bathroom need at 0100 [1:00 am] 0300 [3 am] [and] also repositioned. Unclear as to when the pad was placed on her [lower] legs [and] ankles but notified the nurse [at] the time that she was c/o [lower] leg/feet pain. [NA's name] said that he thought the heating pad had 4 settings [and] she asked him to turn it up. He thought he set it on the 2nd or 3rd setting. Recalled that the heating pad was white [with] a white cover." On 6/15/06 at approximately 3:00 pm, the surveyors observed the resident's right leg and foot during a dressing change to wounds on her heel and lower extremity. The resident was sitting in a reclined position. She had bilateral heel protectors on. The right lower extremity had a Kerlix wrap which extended beyond the heel protector. The exposed area of her anterior lower extremity, beyond the Kerlix wrap, was noted to be very red, taut and edematous. This area was approximately 20 centimeters (cms) above the ankle region. The LN removed the heel protector and the dressings. As the LN was removing the Kerlix wrap a faint foul odor was emitted from the area of the wound. The surveyor was standing approximately 5 feet from the resident's lower extremity. As the surveyor leaned within 2 - 3 feet of the wound, the odor was more apparent. The following was observed: The resident's medial right heel was covered by firmly attached black, dry eschar, measuring 4.0 x 4.5 -5.0 cms. The immediate surrounding skin was deep red, measuring 4.5 cms inferiorly, 1.0 cm medially, and 2.5 cms superiorly to the eschar	F 323	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and medicare programs.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 29 margins. There was a second wound along the resident's medial lower extremity, approximately 3.6 to 4.8 cms above the heel eschar. This wound was irregularly shaped and measured approximately 3.5 x 4.0 cms. The wound bed was covered with 50 - 60% pale yellow mucoid tissue. The remainder of the wound bed contained pink granulating tissue. The immediate surrounding skin was deep red, measuring from 0.5 - 1.0 cm along the inferolateral wound margins, to 2.0 - 4.5 cms along the superolateral wound margins. The anterior lower extremity intact skin was described previously. The resident's son was interviewed on 6/15/06 at approximately 3:10 pm. He indicated he brought the heating pad in shortly after the resident was admitted "...when I moved her things in...I didn't know it was against the rules..." The resident's son stated he had spoken with her regarding the circumstances surrounding the burns and she told him that she had asked the aides to put it on her feet and ankles due to pain and as per her habit, asked for it to be set on the lowest setting. The DON was interviewed on 6/15/06 at 3:50 pm, regarding the burns the resident sustained on 5/18/06. She stated, "...the CNAs found the heating pad on [resident #1] at 0600...it had been on all night...the family brought the heating pad in that day..." The DON noted that no-one had admitted to placing the heating pad on the resident initially and that she had been "...toileted twice..." during the night and no-one remembered seeing the heating pad. She stated, "...at some time during the night, someone placed the heating pad on her chest.." and at 6:00 am, staff put the heating pad between the resident's heels.	F 323	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. THey are required by the Medicaid and Medicare programs.	

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	135018	A. BUILDING _____ B. WING _____	C 06/16/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 30 The DON was interviewed again on 6/15/06 at 6:30 pm, regarding the burns sustained from the heating pad incident on 5/18/06. The DON stated she did not examine the resident's skin immediately after she was burned, "I relied on nursing notes..." When asked when she had first observed the burns, she stated, "Exactly when you saw them..." On 5/23/06, via telephone order, the physician requested a physical therapy consultation to evaluate and treat the resident's burns. The physical therapy notes documented an initial assessment of the burns on 5/24/06 with a plan of treatment to consist of wound care 4 to 5 times per week and as needed with sharps debridement as necessary. Review of the record revealed this treatment was performed as recommended and continued on this schedule until the complaint investigation of 6/15/06. Documentation from the resident's emergency visit on 6/15/06 revealed the following orders: "1) Pt [patient] Needs Aggressive Physical therapy for debridement of [right] ankle [and] foot daily. 2) Rocephin [1] GM [gram] IVPB [intravenous piggy-back] Daily. If any [underscored] worsening then Return immediately to Emergency Department - fever - chills - Rigors - [increased] pain. [Name of resident's physician] to see within 3 days [underscored] to establish treatment plan and length time on antibiotics." The resident's emergency room record, dated 6/15/06, revealed a diagnosis of "acute cellulitis [right] lower leg secondary to burn and large decubitus...Decubitus is of heel burn medial leg at	F 323	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	

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F 323	Continued From page 31 ankle." The resident's wound was cultured and an emergency room notation, dated 6/18/06, documented a positive MRSA (Methicillin Resistant Staphylococcus Aureus) culture. The resident was seen by her personal physician on 6/19/06 for further evaluation. The physician's notes documented the following: "Plan: Will change her meds [medications] to match her cultures...Will have wound specialist see her about her heel and right leg...She is to see [name of physician] about her pain control..." The facility did not ensure the resident's environment was free from environmental hazards by allowing a heating pad into the facility. The facility's staff documented the presence of the heating pad on 4/22/06 on an inventory list. Despite observing the heating pad on the resident on at least 2 occasions, facility staff failed to remove it and one staff member admitted he turned it up to the "...2nd or 3rd setting..." Due to the facility's failure to ensure a safe environment, the resident sustained 2nd and 3rd degree thermal burns to her right heel and lower extremity which resulted in harm and subsequent immediate jeopardy. At the time of the complaint investigation, the resident's burns and surrounding tissue were observed to be inflamed and edematous. The resident had not been seen by a physician until after the surveyors entered the facility approximately 27 days after sustaining the burns. The emergency room physician immediately started the resident on antibiotics, ordered "...aggressive physical therapy for debridement of [right] ankle..." and requested the resident's regular physician examine her within 3 days. The resident was subsequently diagnosed	F 323	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	

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F 323	Continued From page 32 with MRSA infection in her wound and required aggressive treatment with antibiotics as well as a referral to a wound specialist. The resident suffered from physical and psychological trauma since sustaining the burns and was often afflicted with increasing unmanageable pain.	F 323	The answers to the stated dediciencies are not an admission of guilt and therefore cannot be used against this facility in a court of law. They are required by the "e Medicaid and Medicare programs.	
F 441 SS=G	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation it was determined the facility did not ensure that 1 of 1 sampled resident (#1) received proper wound care to prevent wound infection and the possibility of transmission of infection to other residents. Findings include: Resident #1 was admitted to the facility on 4/12/06 with diagnoses including history of cerebral vascular accident, osteoarthritis, vascular dementia, neuropathy, dysphagia, edema, leg pain, paraparesis, low back pain and pressure ulcer to the buttock region.	F 441	1.)This facility has a infection control program in place. The nurse failed to follow our program regarding dressing changes. The nurse in question has been reprimanded and has received inservice on proper procedures for changing dressing. 2.) All licensed staff will attend inservice programs on dressing changes. Once they attend the inservice, they will then demonstrate the proper procedure for changing a dressing, the Inservice Director will record the results of the demonstration and once the staff member performs the procedure flawlessly. The staff member will then demonstrate the procedure to the DNS. 3.) Inservices will be held at least quarterly regarding dressing changes. Staff will will demonstrate the proper procedure to our Inservice Director, DNS or our QA nurse at least yearly 4.) Our Inservice Director, QA nurse and our DNS will monitor this program to ensure our policies and procedures are followed. 7-20-06	

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F 441	Continued From page 33 On 6/15/06 at approximately 3:00 pm, two surveyors observed an LN perform wound care to resident #1's right heel and lower extremity. Also present in the resident's room were the resident's son, the DON and a physical therapy assistant. The LN placed a towel rather than a protective barrier under the resident's right lower extremity. He placed the scissors on the window sill and placed the packaged wound care supplies on the floor rather than on a clean surface draped by a protective barrier. He applied clean gloves and removed the contaminated dressings. He discarded the dressings, and without first removing his contaminated gloves and sanitizing his hands, he cleansed the wounds with gauze pads. He removed the petroleum gauze dressing from its package and retrieved the scissors from the window sill. The surveyor intervened when he started to use the scissors to cut the gauze without first sanitizing the scissors. A staff member left the room and brought back alcohol pads which the LN used to clean the scissors. After he applied the wound contact dressings, and still wearing his contaminated gloves, he picked up the Kerlix package from the floor, removed the Kerlix from the package and wrapped the resident's foot and lower extremity. He reached inside his uniform pocket with the contaminated glove and removed a roll of tape. He used this tape to secure the Kerlix instead of using a clean roll or a roll which was to be used only for this resident. The LN then removed his contaminated gloves and, without sanitizing his hands, he picked up the remainder of the wound care supplies and the contaminated scissors and left the room. The surveyor observed him to place these items on the counter at the nursing station.	F 441	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	

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F 441	Continued From page 34 After the LN returned to the resident's room, he assisted the physical therapy assistant to place the resident in bed. The bed linen at the foot of the bed fell to the floor. Instead of obtaining clean linen, the staff put this linen over the resident's lower extremities. A pillow was observed to be stained with large spots of dried to drying serosanguinous fluid. The physical therapy assistant placed the contaminated pillow on the resident's recliner instead of removing the pillow case and sanitizing the pillow. The resident was transported to the Emergency Room that same afternoon for wound evaluation and treatment secondary to an apparent cellulitis to her right lower extremity. The wound culture taken at the Emergency Room identified Methicillin-resistant Staphylococcus aureus infection. The resident required intravenous antibiotics.	F 441	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicare and Medicaid programs.	
F 490 SS=G	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, review of incident/accident reports, record review, staff interview, and a complaint from the public, it was determined the facility Administrator and Director of Nursing did	F 490	1.) The residents total plan of care has been reviewed and revised to ensure she reaches her highest practical physical, mental and psychosocial well-being. 2.) This facility has policies and procedures that cover each aspect of this deficiency. They have been reviewed and revised. The Administrator has received a reprimand for not ensuring these policies were followed. 3.) Inservices are being conducted on	

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F 490	Continued From page 35 not manage the facility in a manner which prevented immediate jeopardy and harm to one of one sampled resident (#1). This resulted in second and third degree thermal burns to the resident's right lower extremity, the development of an unstageable pressure ulcer to the right heel, and poorly controlled pain management. The Administrator did not thoroughly investigate the thermal injury to rule out neglect or abuse. Additionally, the Administrator and Director of Nursing did not ensure that policies and procedures were implemented to prevent the possibility of neglect or abuse and the transmission of infection. Findings include: Care issues related to Administrator management resulted in immediate jeopardy, harm, and the potential for harm to Resident #1 in the following citations: 1. Resident #1 was admitted to the facility without a pressure ulcer to her right heel. She developed a large unstageable pressure ulcer to the site. The resident did not receive the necessary care and services to prevent the ulcer from developing. The facility did not perform appropriate skin assessments which would have identified the beginnings of a stage 1 pressure injury. This lack of preventative measures and ongoing skin assessments led to the development of a large unstageable pressure ulcer which constituted immediate jeopardy. Please refer to F 314. 2. The facility failed to ensure a resident's environment remained free of accident hazards as possible. This failed practice resulted in serious harm, constituting immediate jeopardy to resident #1. Staff placed a heating pad on or	F 490	on heating pads, dressing changes, pain management, accident investigations, wound care and skin assessments. All staff will be required to abide by our policies at all times. 4.) This will be monitored by our In-service Director, our DNS and the Administrator 7-20-06 The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicare and Medicaid programs.	

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F 490	Continued From page 36 near the resident's feet and lower extremities causing thermal burns at the second and third degree level. The resident sustained thermal burns to the right medial heel and right medial lower extremity on 5/17/06 or 5/18/06. Please refer to F 323. 3. The Administrator failed to thoroughly investigate an incident regarding a specific resident to rule out abuse or neglect. Resident #1 sustained second and third degree thermal burns to her right heel and lower extremity on 5/17/06 or 5/18/06 from a heating pad placed on or near her feet and ankles resulting in harm to the resident. The incident was not thoroughly investigated. Please refer to F 225. 4. Resident #1 sustained thermal burns to the right medial heel and right medial lower extremity on 5/17/06 or 5/18/06. The resident experienced increasing pain over the course of the next 27 days resulting in harm to the resident. There was no evidence that the resident had an initial evaluation and ongoing medical assessments by a physician since sustaining the burns. Please refer to F 309. 5. The Administrator failed to ensure medical supervision, assessment and management was received for resident #1. This resulted in harm when the resident sustained pressure ulcers, thermal injuries, and uncontrolled pain management. Please refer to F 501. 6. The Administrator and DON did not ensure that resident #1 received proper wound care to prevent the possibility of wound infection and the transmission of infection to other residents. This	F 490	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by th the Medicaid and Medicare programs.	

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F 490	Continued From page 37 resulted in the potential for harm to this resident and all the residents in the facility. Please refer to F 441.	F 490	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	
F 501 SS=G	483.75(i) MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and a complaint from the public, it was determined the facility failed to involve the medical director regarding a resident's care when the resident continued to experience pain and suffering from her second and third degree wounds which were being inadequately managed. This resulted in harm to the resident who sustained thermal burns to the right medial heel and right medial lower extremity on 5/17/06 or 5/18/06 and experienced increasing pain over the course of the next 27 days. This was true for 1 of 1 sampled residents (#1). Findings include: Resident #1 was admitted to the facility on 4/12/06 with diagnoses including history of cerebral vascular accident, osteoarthritis, vascular dementia, neuropathy, dysphagia, edema, leg pain, paraparesis and low back pain. On 5/17/06 or 5/18/06, the resident sustained	F 501	1.) This facility has two Medical Directors on contract, unfortunately neither were called in to assist on this case. However, the resident has now been seen by emergency room physicians and her attending physician. Her care plan has been revised and her pain is currently bein being managed effectly. 2.) Our Medical Directors contract specifies the role of the Medical Director. We will write a policy for the policy manual which will specify their duties and when nursing staff should call them in on a case. 3.) Staff will receive inservices on the role of our Medical Director and when they should ask the DNS to notify the Medical Director to intervene when we feel the appropriate care is not being given by the residents attending physician. 4.) This will be monitored by the DNS, QA Nurse and the Administrator. 7-20-06	

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F 501	Continued From page 38 second and third degree burns when a heating pad was left on or near her lower extremities for an extended period of time. Review of the resident's nursing notes from 5/18/06 through 6/15/06 documented the resident received poor pain control management when it was identified that her pain level was at times as high as 7 or 8 on a 1 to 10 pain scale even though she was receiving narcotic medication. Nursing staff did not recognize the importance of being proactive and assess and medicate the resident at regular intervals to ensure her pain was minimal and keep her as pain free as possible. When the facility involved the resident's personal physician, nursing note documentation revealed "Phys [physician] returned call refused stronger Pain med. Suggest pain specialist appointment..." On 5/30/06, eight days later, the nursing notes documented, "...[name of pain specialist] was attempted per phone for pain consult." At the time of the complaint investigation, the resident still had not been evaluated by a pain specialist for her uncontrolled pain. The facility failed to advocate for the resident in order to ensure pain control was properly managed by either transferring her to the emergency room or contacting the medical director when staff was fully aware the resident was suffering from uncontrolled pain. The facility did not ensure the resident received appropriate medical management and ongoing medical treatment after she sustained the thermal burns which caused increased uncontrolled pain. No physician evaluated the resident's burns until 6/15/06, nearly a month after the initial injury, when the surveyors called immediate jeopardy	F 501	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and medicare programs.	

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F 501	Continued From page 39 requiring the resident be transported to the emergency room. Upon evaluation at the emergency room, the resident was diagnosed with acute cellulitis and was started on intravenous antibiotics. The emergency room physician ordered the resident to be seen by her treating physician within 3 days and to begin "...aggressive physical therapy for debridement of [right] ankle..." The resident was subsequently diagnosed with MRSA (Methicillin-resistant Staphylococcus aureus) infection in her wound and required aggressive treatment with antibiotics as well as a referral to a wound specialist. An interview was conducted with the Assistant Administrator and the DON on 6/15/06 at approximately 6:30 pm. The DON could provide no policy regarding the role of the medical director in the facility. The DON stated that nursing staff documented concerns in a communication book. If nursing staff was awaiting a call back from a physician, it would be documented in the communication book for follow-up. The Assistant Administrator stated he remembered reading nursing staff documentation in the communication book referencing awaiting a return call from resident #1's physician. The surveyor asked what was the follow-up procedure for information documented in the communication book. They could offer no information regarding the communication follow-up procedure. In the afternoon of 6/16/06 during an interview with the Administrator, Assistant Administrator and DON, the Administrator acknowledged he had not involved the medical director after it became apparent that the resident's medical needs were not being met.	F 501	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. they are required by the Medicaid and Medicare programs.	

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C 000	INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during a complaint investigation at the facility. The surveyors conducting the survey were: Marcia Key, RN Team Coordinator Lisa Kaiser, RNSurvey Definitions: MDS = Minimum Data Set assessment RAP = Resident Assessment Protocol RAI = Resident Assessment Instrument DON = Director of Nursing LN = Licensed Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	C 000	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs. RECEIVED JUL 10 2006 FACILITY STANDARDS	
C 175	02.100,12,f f. Immediate investigation of the cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted. This Rule is not met as evidenced by: Please refer to F 225 as it relates to the facility's failure to thoroughly investigate incident/accidents to rule out abuse or neglect.	C 175	Please see the answer to F225 as it pertains to this deficiency.	7-20-06
C 442	02.120,12,b b. Portable comfort heating devices shall not be used. This Rule is not met as evidenced by:	C 442		

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135018	A. BUILDING _____ B. WING _____	C 06/16/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST HAVEN CONVALESCENT CTR	1071 RENEE AVE POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 442	Continued From page 1 Please refer to F 323 as it refers to a resident sustaining thermal burns as a result of staff placing a heating pad on or near her lower extremities.	C 442	Please refer to the answer to F323 as it pertains to this deficiency.	7-20-06
C 670	02.150,03,a a. Applied aseptic or isolation techniques by staff. This Rule is not met as evidenced by: Please refer to F 441 as it refers to the facility's failure to ensure a resident received proper wound care in order to prevent the possibility of infection or spreading infection.	C 670	Please refer to the answer to F441 as it pertains to this deficiency.	7-20-06
C 784	02.200,03,b b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please refer to F 309 as it relates to the facility's failure to adequately manage a resident's pain.	C 784	Please refer to the answer to F309 as it pertains to this deficiency The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law.	7-20-06
C 789	02.200,03,b,v v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Based on observations, staff interviews, record	C 789	1.) We hired a Certified Wound Care specialist to assist in the following areas: A.) Review our current wound care policies and procedures and revise them as needed. B.) Oversee the wound care treatments in this facility.	

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C 789	Continued From page 2 reviews, and a complaint from the public, it was determined the facility failed to ensure a resident did not develop a pressure ulcer while in the facility. This failed practice resulted in serious harm, constituting immediate jeopardy to 1 of 1 (#1) sampled residents who sustained a large unstageable pressure ulcer to her right medial heel. The facility could provide no documentation as to the circumstance of when the heel ulcer actually developed in the facility or that the heel was evaluated. The facility failed to implement appropriate management or appropriate interventions to prevent further deterioration. The facility also failed to notify the resident's physician after the unstageable pressure ulcer was first observed by the staff. The right heel and lower extremity became infected as a result of this failed practice. The resident sustained second and third degree burns to the site which contributed to the infection. This failed practice was brought to the attention of the facility's Administrator, DON, and Assistant Administrator on 6/16/06, at 10:00 am. These staff were provided with specific details of the failure to ensure the resident did not develop a pressure ulcer. On 6/16/06 at 1:40 pm, the facility presented the surveyors with an acceptable plan of correction and the immediate jeopardy was abated. The plan of correction was as follows: "We will hire a CWCN [Certified Wound Care Nurse] on a consultant basis to perform the following for this facility: 1.) A CWCN or Certified wound care Specialist [CWS] shall be in the facility no later than 6/21/06	C 789	C.) Provide inservices to our staff on an ongoing basis regarding our wound care program and appropriate wound care technique. 2.) The care plan and plan of treatment for this resident has been rewritten to ensure she is receiving the proper treatment as ordered by her attending physician to heal the wound and protect her from developing any additional skin problems. 3.) Our DNS has completed skin assessments on every patient in this facility and the care plans have been updated where needed (copies of these assessments were fqxed to the surveyors). 4.) Skin assessments will be performed by our licensed staff and appropriate care plans will be developed based on these assessments. These assessments will be completed onthe following schedules: A.) Upon admission B.) If there are no skin care problems Licensed staff will complete assessments weekly. C.) If upon the completion of the initial assessment there is impairment in the skin integrity, Licensed staff will notify the attending physician, the residents family and the Certified Wound Care Specialist. Orders for treatment and a plan of treatment will be developed and the treatment will begin immediately. D.) A nutritional assessment will be completed upon each admission.	

The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.

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C 789	Continued From page 3 at 7:00 am. 2.) In order to ensure no other residents are effected our Director of Nursing and one other RN is also completing head to toe skin assessments on every resident curretnly [sic] in our facility and will fax these to the surveyor on Monday, 6/19/06, by 2:00 pm. 3.) Review our current wound care policies and procedures including treatment and prevention and revise these policies where necessary. To ensure this does not occur again. 4.) Oversee treatments of wounds on patients in this facility. 5.) Provide inservices education to our staff on a ongoing basis regarding our wound care program and appropriate wound care techniques. Skin assessments will be performed by our licensed staff and appropriate care plans will be developed based on these assessment. These assessments will be completed on the following schedules. 1.) Upon admission. 2.) If there are no skin care problems licensed staff will complete assessment weekly. 3.) If, upon completion of the initial skin assessment there is impairment in the skin integrity, licensed staff will notify the attending physician, the residents family and the CWCN or CWS consultant. Orders for treatment and the plan of treatment will be obtained and treatment will begin.	C 789	Physicians of residents who suffer from skin impairment will be notified and supplements will be ordered taking into account the residents total condition. Additional dietary assessments will be completed on a monthly basis for those residents suffering from skin impairment. E.) This will be montiored by our DNS, Dietary Supervisor, and QA Nurse 7-20-06 The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. they are required by Medicaid and Medicare programs.	

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C 789	Continued From page 4 4.) A nutritional assessment will be completed upon each admission. Physicians of residents who suffer from skin impairment will be notified and supplements will be ordered taking into accounts the Residents total condition. Additional dietary assessment will be completed on a monthly basis for those residents suffering from skin impairment. Date [to be] completed 6/23/06." Findings include: Resident #1 was admitted to the facility on 4/12/06 with diagnoses including history of cerebral vascular accident, osteoarthritis, vascular dementia, neuropathy, dysphagia, edema, leg pain, paraparesis, low back pain and pressure ulcer to the buttock region. The complaint team entered the facility on 6/15/06 at 2:45 pm, in order to investigate an allegation that resident #1 had sustained second and third degree burns as a result of the facility's use of a heating pad. The complaint team asked for the resident's chart and requested the DON to accompany the two surveyors to resident #1's room in order to visualize the resident's right lower extremity. The DON, the charge LN, and a physical therapy assistant entered the resident's room with the surveyors. The resident was sitting in her recliner. Her son was also present. The resident was sitting in a reclined position. She was wearing bilateral heel protectors. The right lower extremity had a Kerlix wrap which extended beyond the heel protector. The exposed area of her anterior lower extremity, beyond the Kerlix wrap, was noted to be very red, taut and edematous. This area was approximately 20 centimeters (cms) above the ankle region. The	C 789	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	

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C 789	Continued From page 5 LN removed the heel protector and the dressings. As the LN was removing the Kerlix wrap a faint foul odor was emitted from the area of the wound. The surveyor was standing approximately 5 feet from the resident's lower extremity. As the surveyor leaned within 2 - 3 feet of the wound, the odor was more apparent. The following was observed: The resident's medial right heel was covered by firmly attached black, dry eschar, measuring 4.0 x 4.5 -5.0 cms. The immediate surrounding skin was deep red, measuring 4.5 cms inferiorly, 1.0 cm medially, and 2.5 cms superiorly to the eschar margins. There was a second wound along the resident's medial lower extremity, approximately 3.6 to 4.8 cms above the heel eschar. This wound was irregularly shaped and measured approximately 3.5 x 4.0 cms. The wound bed was covered with 50 - 60% pale yellow mucoid tissue. The remainder of the wound bed contained pink granulating tissue. The immediate surrounding skin was deep red, measuring from 0.5 - 1.0 cm along the inferolateral wound margins, to 2.0 - 4.5 cms along the superolateral wound margins. The anterior lower extremity intact skin was described previously. After viewing the resident's right lower extremity wounds, the survey team asked to speak with the Administrator, the assistant Administrator and the DON at 4:30 pm. During the interview the Administrator indicated that the resident was admitted to the facility with a "black cap" on her right heel and that the physical therapist could verify that the "black cap" on the resident's heel was still present at the time the resident sustained the burn on the heel from the heating pad.	C 789	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	

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C 789	Continued From page 6 The surveyor spoke to the physical therapist via telephone at 4:44 pm. The therapist indicated the resident was admitted to the facility with a black heel. The therapist also indicated that an LN asked him to assess the heel. He recalled he instructed the staff to keep the area dry and not attempt to remove the black eschar. He stated he was not sure if he documented his assessment. When he saw the thermal injuries, he noticed there was a blister on top of the original eschar. Once the blister opened the original black eschar was again observed. He also stated the therapy department had photographs of the wounds since they initiated treatment on 5/24/06. He stated the first photograph taken 5/24/06 showed the original heel eschar. He agreed to produce color copies of the right heel and lower extremity wounds for the surveyors. The physical therapy notes were reviewed for 5/24/06 and documented the following: "...The heel wound is 7.3 cm x 6 cm. It is important to note that the heel wound necrosis in the center is from the previous pressure ulcer and not from the burn (she had a [sic] intact heel cap previously)". The resident's admission nursing assessment, dated, 4/12/06, was reviewed by the DON and the surveyors. The Comprehensive Skin Assessment section, also dated 4/12/06, identified the following: "Bruises Bil[ateral] areas front [word not legible] - rt [right] hand swollen & bruised - Bruise bil leg posterior & anterior - 4 cm open area on lt [left] inner buttock [words not legible] cream apply - nail lt foot [word not legible] 4th & 5th toe on medial side of 5th toe 2 inches long 1/8 deep...Bil heel protectors on." The body diagram on the form identified the multiple upper and lower extremity bruising and the open area to the right buttock region. There was no identified injury to	C 789	The answers to the stated deficiencies are not an admisssion of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	

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C 789	Continued From page 7 the resident's right heel. The admission nurses' notes, dated 4/12/06, also identified the above skin issues. There was no mention of a right heel injury. The physical therapist came to the facility 6/15/06 and was interviewed by the two surveyors at 6:10 pm. He stated he had attempted to locate his assessment notes for the time period when he evaluated the resident's heel. "I didn't see her when she first came in. I can't find my notes." He stated he was certain the resident had black eschar on her right heel prior to the thermal injury to the site. He acknowledged he was not sure if she was admitted to the facility with the pressure ulcer. The surveyors reviewed the Daily CNA Skin Check Sheet. The documentation identified from 4/13/06 through 5/18/06 that the resident had no impaired skin. This documentation contradicted the initial nursing assessment as identified earlier. The Skin Problem Assessment Flow Sheet was initiated on 5/18/06, the day the thermal injuries were sustained. The right heel was described as a "blister burn" and the color was "purple." There was no documentation prior to 5/18/06 that identified the resident had black eschar on the right heel. There was no physician notification after the physical therapist became alerted by an LN that the resident had developed an unstageable pressure ulcer. There was no immediate care plan initiated to direct the staff how to protect the heel from further pressure and to protect other vulnerable areas prone to increased pressure.	C 789	The answers to the stated deficiancies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	

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C 789	Continued From page 8 The facility failed to assess, monitor and treat a large black eschar to the resident's right heel that developed after she was admitted to the facility. This failed practice resulted in immediate jeopardy.	C 789	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	
C 790	02.200,03,b,vi vi. Protection from accident or injury; This Rule is not met as evidenced by: Based on observations, staff and family interviews, record review, and a complaint from the public it was determined the facility failed to ensure a resident's environment remained free of accident hazards as possible. This failed practice resulted in serious harm, constituting immediate jeopardy to 1 of 1 (#1) sample residents. A heating pad was placed on or near the resident's feet and lower extremities causing thermal burns at the 2nd and 3rd degree level. The resident sustained thermal burns to the right medial heel and right medial lower extremity on 5/17/06 or 5/18/06. The resident experienced increasing pain over the course of the next 27 days. The facility could provide no documentation that the resident had an initial evaluation and ongoing medical assessments by a physician since sustaining the burns. The facility failed to thoroughly investigate the circumstances surrounding this incident. This failed practice was brought to the attention of the facility's Administrator, DON, and Assistant Administrator on 6/15/06, at 4:30 pm and the facility was provided with specific details of the failure to ensure the resident's environment remained free of accident hazards. At this time, the Administrator indicated heating pads were not allowed in the facility.	C 790	Each resident at this facility will be assured their environment is as free of hazards as possible. 1.) The heating pad has been removed from the facility. 2.) The rooms of all other residents have thoroughly checked to ensure there are no other heating pads in our facility. 3.) Signs have been posted in the facility indicating the use of heating pads is prohibited. We have added language to our admission agreement indicating the use of heating pads is prohibited. We have also sent out notices informing families of residents of our policy regarding heating pads. We will provide quarterly inservices to remind staff of our policy regarding heating pads. Staff and members of the QA committee will monitor the facility for heating pads during their QA rounds. and unit cleans. 4.) This will be monitored by our DNS, Administrator and our Inservice Director.	7-20-06

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C 790	Continued From page 9 Idaho state rules prohibit portable heating devices in long-term care facilities. Prior to submitting an acceptable plan of correction, the surveyors were informed that the resident had been transported to a local emergency room at approximately 4:45 pm on 6/15/06. On 6/15/06, at approximately 8:45 pm, the facility presented the surveyors with an acceptable plan of correction and the immediate jeopardy was abated. The plan of correction was as follows: "Each resident at the facility will be assured an environment free of hazards. All resident rooms have been searched for any heating pads that may be in their rooms and removed. Signs will be made and posted throughout the facility as to the policy of Hillcrest which is there is [sic] no heating pads allowed in the facility for resident use. We will add language to our admission agreement stating that this facility does not allow the use of heating pads. We will also make a notation on our resident inventory list that heating pads are not allowed. The facility will also send a notice out to all residents and their interested parties informing them of the policy of not utilizing heating pads in this facility. The facility will provide quarterly inservices to staff to re-educate and remind them of the policy. Staff will monitor rooms for heating pads during their quality assurance rounds and during the unit cleans which are scheduled bi-monthly. As noted in the statement the facility did transport this resident to the emergency room this afternoon for evaluation by a physician. Corrective Actions will be	C 790	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	

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C 790	Continued From page 10 completed by 6/23/2006." The facility presented the surveyors with a written statement, signed by a staff member, dated 6/15/06 at 4:00 pm, that stated the following: "I checked rooms for heating pads per your request, none were found..." Findings include: Resident #1 was admitted to the facility on 4/12/06 with diagnoses including history of cerebral vascular accident, osteoarthritis, vascular dementia, neuropathy, dysphagia, edema, leg pain, paraparesis and low back pain. A handwritten inventory list, attached to facility's "Clothing And Valuable List," dated 4/22/06, documented "...(1) Heating pad..." A "Resident Incident/Unusual Occurrence Report," dated 5/18/06 at 7:20 am, documented two CNAs had entered the resident's room to get her up and discovered a heating pad "...between her heels." The report documented the CNAs "...observed some redness on the Right heel..." and notified a nurse immediately. Attached to the incident report was an "Incident Report Investigation, " dated 5/18/06. The investigation report included the following information: "...This morning at 0720 [7:20 am], 2 CNAs went into [resident #1's] room to assist her with preparations for the day. As they pulled the blankets down, they noticed a heating pad on her feet, between the heels. When they removed the heating pad, some redness was noted on the right heel...Upon investigating the incident, it was	C 790	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. they are required by Medicaid and medicare programs.	

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C 790	Continued From page 11 determined that the family had brought in the heating pad for the resident. The heating pad was placed on her feet at 0600 [6:00 am]. The staff had just assisted her with toileting at 0600. The resident had been physically viewed 5 minutes prior when she was noted to be resting. Family and physician were notified. I interviewed and spoke with the staff that worked that night, inservicing them on the policy that we do not utilize any heating pads in the facility. Family were notified and the heating pad was removed from the building." The resident's nursing notes were reviewed. The documentation revealed an entry dated 5/18/06 at 3:30 pm that stated, "Res[ident] family brought heating pad in from other facility, res requested heating pad to be put on. Nursing staff was unaware of heating pad was in RM [room]. Aids [sic] found heating pad, put on Res feet, when arriving to work for shift, observed Res [with] 2 blisters on feet, notified family [and] MD [medical doctor], Son has stated he was going to take pad home." At the request of the surveyors, the LN on duty on 5/18/06, wrote a statement on 6/15/06. The LN noted that when she arrived in the resident's room, she observed "...a heating pad under her [resident #1] R [right] foot and ankle..." Upon assessing the right leg, the LN noted "...a red area on the heel and bottom of foot, when I pressed the skin around the red area it blanched..." The LN documented that she had provided basic first aid for the reddened area and applied a brace to the resident's foot. The LN documented, "...At 0930 [9:30 am] the aid [sic] came and got me once again to look at the ankle. At this time, I unwrapped the foot and I observed the ankle having a blister on it and the red area	C 790	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	

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C 790	Continued From page 12 on the heel and bottom of foot was blistered. I then got two clean/new non-adhesive pads and two clean/new rolls of curlex [sic] and re-wrapped the ankle and foot and put the AFO [ankle-foot orthoses] brace back on." On 6/15/06, the DON spoke with a night shift LN who worked on 5/18/06 and documented the following: "Med[icated] [resident #1] [at] 0430 [4:30 am] for pain when he was notified by CNA that she was c/o [complaining of] pain in lower extremities. Had no knowledge of a heating pad on Res. [resident] [at] any time until he came to work the next noc [night] [after] incident." On 6/15/06, the DON spoke with an NA who worked the night shift on 5/18/06 and documented the following: "Stated he saw the heating pad on her chest on 1st Rounds [at] 2300 [11:00 pm]. She was checked for bathroom need at 0100 [1:00 am] 0300 [3 am] [and] also repositioned. Unclear as to when the pad was placed on her [lower] legs [and] ankles but notified the nurse [at] the time that she was c/o [lower] leg/feet pain. [NA's name] said that he thought the heating pad had 4 settings [and] she asked him to turn it up. He thought he set it on the 2nd or 3rd setting. Recalled that the heating pad was white [with] a white cover." On 6/15/06 at approximately 3:00 pm, the surveyors observed the resident's right leg and foot during a dressing change to wounds on her heel and lower extremity. The resident was sitting in a reclined position. She had bilateral heel protectors on. The right lower extremity had a Kerlix wrap which extended beyond the heel protector. The exposed area of her anterior lower extremity, beyond the Kerlix wrap, was noted to be very red, taut and edematous. This area was	C 790	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and medicare programs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135018	A. BUILDING _____ B. WING _____	C 06/16/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 790	Continued From page 13 approximately 20 centimeters (cms) above the ankle region. The LN removed the heel protector and the dressings. As the LN was removing the Kerlix wrap a faint foul odor was emitted from the area of the wound. The surveyor was standing approximately 5 feet from the resident's lower extremity. As the surveyor leaned within 2 - 3 feet of the wound, the odor was more apparent. The following was observed: The resident's medial right heel was covered by firmly attached black, dry eschar, measuring 4.0 x 4.5 -5.0 cms. The immediate surrounding skin was deep red, measuring 4.5 cms inferiorly, 1.0 cm medially, and 2.5 cms superiorly to the eschar margins. There was a second wound along the resident's medial lower extremity, approximately 3.6 to 4.8 cms above the heel eschar. This wound was irregularly shaped and measured approximately 3.5 x 4.0 cms. The wound bed was covered with 50 - 60% pale yellow mucoid tissue. The remainder of the wound bed contained pink granulating tissue. The immediate surrounding skin was deep red, measuring from 0.5 - 1.0 cm along the inferolateral wound margins, to 2.0 - 4.5 cms along the superolateral wound margins. The anterior lower extremity intact skin was described previously. The resident's son was interviewed on 6/15/06 at approximately 3:10 pm. He indicated he brought the heating pad in shortly after the resident was admitted "...when I moved her things in...I didn't know it was against the rules..." The resident's son stated he had spoken with her regarding the circumstances surrounding the burns and she told him that she had asked the aides to put it on her feet and ankles due to pain and as per her habit, asked for it to be set on the lowest setting.	C 790	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. they are required by the Medicaid and Medicare programs.	

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C 790	Continued From page 14 The DON was interviewed on 6/15/06 at 3:50 pm, regarding the burns the resident sustained on 5/18/06. She stated, "...the CNAs found the heating pad on [resident #1] at 0600...it had been on all night...the family brought the heating pad in that day..." The DON noted that no-one had admitted to placing the heating pad on the resident initially and that she had been "...toileted twice..." during the night and no-one remembered seeing the heating pad. She stated, "...at some time during the night, someone placed the heating pad on her chest.." and at 6:00 am, staff put the heating pad between the resident's heels. The DON was interviewed again on 6/15/06 at 6:30 pm, regarding the burns sustained from the heating pad incident on 5/18/06. The DON stated she did not examine the resident's skin immediately after she was burned, "I relied on nursing notes..." When asked when she had first observed the burns, she stated, "Exactly when you saw them..." On 5/23/06, via telephone order, the physician requested a physical therapy consultation to evaluate and treat the resident's burns. The physical therapy notes documented an initial assessment of the burns on 5/24/06 with a plan of treatment to consist of wound care 4 to 5 times per week and as needed with sharps debridement as necessary. Review of the record revealed this treatment was performed as recommended and continued on this schedule until the complaint investigation of 6/15/06. Documentation from the resident's emergency visit on 6/15/06 revealed the following orders: "1) Pt [patient] Needs Aggressive Physical therapy for debridement of [right] ankle [and] foot daily. 2) Rocephin [1] GM [gram] IVPB [intravenous	C 790	The answers to the stated deficiencies are not an admission of guilt. Therefore, they acnnot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	

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C 790	Continued From page 15 piggy-back] Daily. If any [underscored] worsening then Return immediately to Emergency Department - fever - chills - Rigors - [increased] pain. [Name of resident's physician] to see within 3 days [underscored] to establish treatment plan and length time on antibiotics." The resident's emergency room record, dated 6/15/06, revealed a diagnosis of "acute cellulitis [right] lower leg secondary to burn and large decubitus...Decubitus is of heel burn medial leg at ankle." The resident's wound was cultured and an emergency room notation, dated 6/18/06, documented a positive MRSA (Methicillin Resistant Staphylococcus Aureus) culture. The resident was seen by her personal physician on 6/19/06 for further evaluation. The physician's notes documented the following: "Plan: Will change her meds [medications] to match her cultures...Will have wound specialist see her about her heel and right leg...She is to see [name of physician] about her pain control..." The facility did not ensure the resident's environment was free from environmental hazards by allowing a heating pad into the facility. The facility's staff documented the presence of the heating pad on 4/22/06 on an inventory list. Despite observing the heating pad on the resident on at least 2 occasions, facility staff failed to remove it and one staff member admitted he turned it up to the "...2nd or 3rd setting..." Due to the facility's failure to ensure a safe environment, the resident sustained 2nd and 3rd degree thermal burns to her right heel and lower extremity which resulted in harm and subsequent immediate jeopardy. At the time of the complaint investigation, the resident's burns and surrounding tissue were observed to be inflamed	C 790	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	

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C 790	Continued From page 16 and edematous. The resident had not been seen by a physician until after the surveyors entered the facility approximately 27 days after sustaining the burns. The emergency room physician immediately started the resident on antibiotics, ordered "...aggressive physical therapy for debridement of [right] ankle..." and requested the resident's regular physician examine her within 3 days. The resident was subsequently diagnosed with MRSA infection in her wound and required aggressive treatment with antibiotics as well as a referral to a wound specialist. The resident suffered from physical and psychological trauma since sustaining the burns and was often afflicted with increasing unmanageable pain.	C 790	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	